

# Diagnostic & Evaluation Clinic Guidelines

## (D&E Clinics)

### 2008

#### General Information:

##### Vision

All children with neuro-developmental disabilities or suspected of having a developmental disability will be identified, evaluated and supported within their community.

##### Mission

The mission of the D&E clinic program is to identify and evaluate children, birth to 21 years, to delineate any medical conditions that may be contributing to developmental delay or disability. In an effort to enhance and support the concept of the Medical Home, each local D&E clinic seeks to combine the expertise of the child's family and local professionals with a physician skilled in evaluating developmental disabilities. The team provides a comprehensive multi-disciplinary diagnostic evaluation and differential diagnosis, with appropriate recommendations for additional testing or treatment. In addition, the D&E Clinic enhances local community capacity to serve families of children who have or are suspected of having neuro-developmental delays.

**Policy:** The D&E clinics are initiated out of local needs for the expertise of a physician skilled in evaluating developmental delays and are supported by the community itself. Although most clinics reside in underserved rural areas, select populations in urban areas are served as well. In addition, all clinics will adopt the concept of regional outreach and make services available to children outside their immediate community. Colorado is a large state and a few resources need to be able to reach the maximum number of children.

#### Procedures:

1. **Contracts:** The state Health Care Program for Children with Special Needs (HCP) office contracts with each D&E clinic to provide diagnostic and evaluation services. In addition, HCP contracts with the Department of Health Care Policy and Financing (HCPF) to reimburse the clinics for those children who are Medicaid eligible.
2. **State Support:** The clinics are given a base operations amount, a per diem physician's honorarium, and a fee for care coordination per child seen. For a clinic to qualify for this support, they must have at least three clinics per year and see six children. Otherwise, there is a start up amount for clinics that provide fewer services. The state also provides medical consultation by a physician and other health staff and oversight by the State D&E Clinic Coordinator.
3. **Advisory Boards:** Each community is expected to develop a local advisory board *with a minimum of **one family representative***. The board should meet at least twice annually. This board will help the team with the selection of appropriate diagnoses to serve, logistical support, marketing and community involvement.

4. Family-Centered Philosophy: The D&E clinic philosophy is that all services should be family-centered. This means that the services are based upon the recognition that the family is the constant in the child's life, while services and personnel within a community change. The clinics are designed to be flexible, accessible, and responsive to families' needs. This is one reason why it is vital to have a family representative on the state and local advisory boards.
5. Culturally and Linguistically Responsive: Each D&E clinic shall be aware of the cultural and linguistic needs of the children and families seen as reflected within their community and respond appropriately to each child's specific needs while providing an assessment and care coordination. Interpretation services and payments are the responsibility of the clinic and may not be charged to the family.\*
6. Local Clinic Coordinator: The local clinic coordinator may be any qualified member of the community that the board approves as appropriate. Qualification of the individual should be as follows: extensive early childhood experience, professional in special education, rehabilitation professional (such as OT/PT or, social worker), nurse or other qualified community individual.
7. Other Team Members: The team is made up of at least four local community professionals and the physician. The make-up of the team may shift from clinic to clinic depending on the child being evaluated. Usually, the team consists of a nurse, speech and language pathologist, occupational/physical therapist and a mental health professional. However, other professionals may be utilized. In addition, clinics are encouraged to utilize community partners which could include the Child Find Team or staff from their local BOCES.
8. Referral Process: All children are required to have a letter of referral from their Primary Care Provider (PCP). The referrals are made to the local clinic coordinator. *It is the responsibility of the local clinic coordinator and community team partners to help the family find the child a PCP if she/he does not have one.*
9. Eligibility Criteria: All children referred must have a suspected health/neuro-developmental/medical delay or be at risk for such.
10. Triage/Selection Process: The clinic coordinator and the advisory board develop a triage team and rationale for selecting children from those who have been referred. Each local clinic coordinator assures that all background information and recent evaluations (within 3 months) are gathered to share with the physician.
11. Domains to be Investigated: Past medical history, including pre- peri- and postnatal history, developmental milestones, family and social history, growth assessments, and present level of functioning in the following areas: cognitive, communication, social-emotional, and motor.

12. Fiscal Agent & Billing: Each D&E clinic is expected to find a fiscal agent who will provide in-kind services. The fiscal agent bills third-party payers and collects the reimbursement, which is then held in an account for the clinic itself. This money may be used with direction from the advisory board to pay clinic expenses such as marketing efforts, paying private specialists, increasing a physician's honorarium, if needed, and paying for the clinic coordinator. In addition, the D&E clinic receives community in-kind efforts to support itself.
13. Medicaid support: Each D&E clinic shall have a physician who must be board certified and approved by the State HCP Diagnostic and Evaluation Clinic Coordinator. In addition, the State shall assure that it has a Memorandum of Understanding (MOU) in place with Medicaid that allows each D&E clinic to bill for approved D&E services and for providers using billing codes provided. These are the T codes which can be found in the Medicaid Reimbursement Agreement form (attachment with this document)
14. Uninsured policy: Each D&E clinic shall provide a written policy to the State D&E Clinic Coordinator which specifically states how and at what rate uninsured children's families shall be billed. Billing of families whose income is 185% of the federal poverty rate is not allowed. (This can be found on the web site as an attachment to this Guideline.)
15. Future planning: The Clinic Coordinator in collaboration with the D&E Advisory Board and the Medical Home Initiative will develop a formalized strategic plan for the next 3-5 years, including a plan to increase the capacity of local PCP's and communities to develop a systematic approach to diagnose neuro-developmental disorders as part of a community's coordinated health system for early diagnosis and treatment of children with special health care needs.

\*Family-centered care and cultural and linguistic competence are essential approaches to address the multiple strengths, needs, and preferences of this nation's families who have children and youth with special health care needs.

#### **Effectiveness Indicators & Components of the D&E Clinic Process:**

1. Compilation and review of background information on each child seen, including any previous evaluations and/or reports.
2. Completion of a Diagnostic & Evaluation Clinic Family Social History, including a social history, by a social worker, nurse or other appropriate professional (psychologist, etc.)
3. Completion of a comprehensive multidisciplinary/interdisciplinary evaluation to identify a child's current developmental functioning, including screening for vision, hearing and social-emotional screenings for all children and youth seen in the clinic.
4. Completion of a medical history and examination of the child by a pediatrician with specialized skills with developmental disabilities.

5. Evidence of family-centeredness and cultural competency throughout the clinic process
6. Opportunity for parent-to-parent support for a family as they and their child go through the evaluation process.
7. Coordination and involvement of community agencies and resources; this is maximized by the Advisory Boards. The community agencies and resources can include any that specifically impact children and families (i.e. local Early Intervention Programs, Child Find or BOCES, health providers, local Health Department or Nursing agency, school systems, mental health providers, funding partners, etc.)
8. Coordination and completion of a Family-Professional Conference with all relevant individuals, such as D&E Clinic Coordinator, family members, physician, staff completing evaluations, community representatives, etc.
9. Development of recommendations with family and professional input, resulting in a documented summary for the family, professionals and primary care provider.
10. Coordination of follow-up and service coordination, as needed. This includes assuring needed care coordination with another entity for the child after the completion of the assessment.

**Responsibilities of the Clinic Coordinator and other staff:**

1. The Clinic Coordinator will coordinate and oversee all clinic activities.
2. Develop family-centered intake process, including consents, releases of information, etc.
3. Ensure Medical Home connection (with PCP) from beginning to end of clinic. To assure this is happening, **the clinic physician will have direct contact with the referring physician** when there are specific recommendations made for follow-up for children seen.
4. Promote public awareness of clinics and ongoing community contacts.
5. Develop an ongoing process for working with community partners to assure continuity of care and as a source of referrals for children to be seen in the D&E clinic.
6. Identify community partners to participate in the Advisory Board, facilitate the meetings and determine the frequency of these meetings.
7. Obtain financial assessment of family (as applicable); this is dependent on the specific D&E Clinic policy for payment from families. This also includes assuring that health insurance plans are current and billing information is available for billing.

8. Contact community professionals to coordinate evaluations, including gross and fine motor, language, hearing, vision and social-emotional screenings for all children seen where applicable.
9. Ensure follow-up with recommendations by providing a written report to the family and the referring physician.
10. Coordinate and share family/child background information and evaluation results with the pediatrician prior to clinic (unless all evaluations take place on the day of the clinic)
11. Maintain organized records for at least seven years past the child's 21<sup>st</sup> birthday to fulfill the HIPAA requirements.
12. Complete Data Summary Sheet on each child that attends the D & E Clinic and to fax to State D & E Clinic Coordinator at (303)753-9249. These sheets will be submitted no later than 30 days after completion of the clinic when the child was seen.
13. CDPHE is currently building an internet-based clinic database that will be implemented in spring of 2009. Each clinic will be responsible for entering client/clinic date into the system at that time. Clinic staff will receive instructions on the use of the database in a timely manner to facilitate a smooth transition to the automated system
14. Complete Annual Diagnostic & Evaluation Clinic Report and submit by Dec. 1, 2009.
15. D&E Clinic staff will provide diagnostic evaluations and case findings for children suspected of having health-related developmental disabilities or delays as follows:
  - ❖ The multi-disciplinary team will consist of at least two professionals in addition to a physician. The physician may be a developmental pediatrician, a pediatrician with additional developmental training or a pediatric physiatrist.
  - ❖ The physician must be board certified and approved by the State HCP Diagnostic and Evaluation Clinic Coordinator. In addition, the physician must have credentialing approval by Health Care Policy and Financing (HCPF) to qualify for Medicaid reimbursement.
  - ❖ The physician will conduct a health related evaluation and examination of each children accepted for service.
  - ❖ A conference will be convened to include both the family and professionals to discuss findings, arrive at diagnoses, and make recommendations for service and/or treatment. The family, other professionals and agencies involved in the child's assessment of care will be included in the conference.
  - ❖ Provide referrals for recommended services and treatment, as appropriate.
  - ❖ Follow-up with the family to assess the impact upon the child and family of any services provided.

**Responsibilities of Clinic Fiscal Agent:**

1. Provide fiscal services for D & E Clinic on an in-kind basis as a community contribution;
2. Bill for services or prepare medical claims for fiscal agent; these funds will be retained by the clinic for further clinic operations
3. Issue payments from D & E Clinic account for clinic coordinator, providers, operating expenses and other obligations;
4. Process medical claims for third party reimbursements;
5. Bill CDPHE contract; this shall be done on a quarterly basis.
6. Manage clinic funds;
7. Report cash balances, expenditures and revenues to D and E Clinic Advisory Board on at least a quarterly basis.

For further information, please refer to the *Developmental Evaluation Clinics Guidelines and Standards Manual*.